Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TX 77029

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-12-0975-01

MFDR Date Received
NOVEMBER 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier's denial states that services performed are outside the scope of practice for the provider. On July 24, 1998 The Texas Board of Chiropractic Examiners ruled that nerve conduction studies were part of the scope of practice of a licensed DC in Texas. These tests would include all nerve conduction studies such as needle EMG, somatosensory evoked potential studies, visual evoked potentials, H reflex, amplitude and latency studies."

Amount in Dispute: $1,749.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier is maintaining their position that Dr. Pedro J. Lozano, DC is not entitled to additional money ($1,749.89) for the 7/6/2011 NCV/EMG testing he performed. The Carrier is standing by their denial based on Judge Stephen Yelenosky's 11/24/2009 Summary Judgment Letter."

Response Submitted By: Chartis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 6, 2011	CPT Code 95903 (X4)	$472.00	$447.47
	CPT Code 95904 (X6)	$570.00	$339.67
	CPT Code 95860	$157.00	$0.00
	CPT Code 99244	$175.89	$0.00
	CPT Code 99070	$25.00	$0.00
	CPT Code 99358	$113.00	$0.00
March 1, 2011	CPT Code 99080	$15.00	$0.00

	CPT Code 95900-59 (X2)	$222.00	$192.76
TOTAL		$1,749.89	$979.90

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §102.3, effective April 28, 2005*, 30 Texas Register 2396,* directs the computation of time and due dates.
2. 28 Texas Administrative Code §133.307, effective May 25, 2008, *33 Texas Register 3954*, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
4. 22 Texas Administrative Code §75, effective December 24, 2009, *34 Texas Register 9208*, sets out the scope of practice for chiropractors.
5. District Court of Travis County, 250th Judicial District No. D-1-N-GN-06-003451, Honorable Stephen Yelenosky, Judge Presiding, Order on cross-motions for partial summary judgment dated November 24, 2009.
6. Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Opinion dated April 5, 2012.
7. Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Mandate dated August 8, 2013.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 185-The rendering provider is not eligible to perform the service billed.
- VH04-Service does not fall within the scope of the providers practice.
- X394-Our position remains the same if you disagree with our decision please contact the TWCC Medical Dispute Resolution
- Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.

Litigation Background for Needle EMG and MUA

Portions of the Texas Board of Chiropractic Examiners rules of practice were challenged by the Texas Medical Association and the Texas Medical Board in 2009. At issue was whether 22 Texas Administrative Code §75.17(a)(3), (c)(2)(D), (c)(3)(A), and (e)(2)(O) were within the scope of chiropractic practice in Texas. Specifically, the parties sought judgment on whether rules allowing Chiropractors to perform needle electromyography (EMG) and manipulation under anesthesia (MUA) were valid. On November 24, 2009, the 345th District Court issued a judgment in which presiding judge Honorable Stephen Yelenosky concluded that needle EMG and MUA exceeded the statutory scope of chiropractic practice in Texas. The Texas Board of Chiropractic Examiners appealed the district court's judgment to the Texas Court of Appeals, Third District. The Texas Court of Appeals in *Tex. Bd. Of Chiropractic Examiners v. Tex. Med. Ass'n*., 375 S.W.3d 464 (Tex. App. – Austin, 2012, pet. den.) issued an opinion affirming the district court's judgment, and concluding that needle EMG and MUA services are not within the chiropractic scope-of-practice. The Chiropractic Board exhausted its appeals and on August 8, 2013, the mandate affirming the district court's judgment was issued. The mandate states "…we affirm the remainder of the district court's judgment that subparts 75.17(a)(3), (c)(2)(D), (c)(3)(A), and (e)(2)(O) of the Texas Board of Chiropractic Examiners' scope-of-practice rule are void." In accordance with the Texas Court of Appeals opinion, the final mandate, and the scope of chiropractic practice requirement in 28 Texas Administrative Code §134.203(a)(6), needle EMG and MUA services may not be reimbursed.

Issues

1. Is the rendering provider eligible to perform needle electromyography?
2. Is the rendering provider eligible to perform an office consultation?
3. Is the requestor entitled to reimbursement for the office consultation?
4. Is the rendering provider eligible to perform the prolonged evaluation services?
5. Is the requestor entitled to reimbursement for the prolonged evaluation services?
6. Is the rendering provider eligible to provide supplies billed under CPT code 99070?

7. Is the requestor entitled to reimbursement for the supplies billed under CPT code 99070?
8. Is the rendering provider eligible to provide special reports billed under CPT code 99080?
9. Is the requestor entitled to reimbursement for special reports billed under CPT code 99080?
10. Is the rendering provider eligible to perform nerve conduction tests?
11. Is the requestor entitled to reimbursement for CPT code 95900?
12. Is the requestor entitled to reimbursement for the nerve conduction tests?

Findings

1. CPT code 95860 is defined as "Needle electromyography; 1 extremity with or without related paraspinal areas." According to the medical documentation found, this service was performed by Pedro J. Lozano, D.C. (Doctor of Chiropractic). The Texas Court of Appeals in *Tex. Bd. Of Chiropractic Examiners v. Tex. Med. Ass'n*., 375 S.W.3d 464 (Tex. App. – Austin, 2012, pet. den.) issued an opinion affirming the district court's judgment, and concluding that needle EMG and MUA services are not within the chiropractic scope-of-practice of chiropractors. 28 Texas Administrative Code §134.203(a)(6) states "Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act." The division finds that disputed service code 95860 is not within the scope of chiropractic practice because it is an electro-diagnostic test that involves the insertion of a needle into the patient. Therefore, no reimbursement can be recommended for CPT code 95860 pursuant to 28 Texas Administrative Code §134.203(a)(6).
2. 28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Disputed service 99244 is an office consultation for a new or established patient (moderate complexity). According to the medical documentation found, this service was performed by Pedro J. Lozano, D.C. (Doctor of Chiropractic). The workers' compensation carrier denied payment because "185-The rendering provider is not eligible to perform the service billed". 22 Texas Administrative Code §75.17(c)(2)(A) states "Examination and Evaluation: (1) In the practice of Chiropractic, licensees of this board provide necessary examination and evaluation of services." The Division finds that 99244 is within the chiropractic scope of practice in Texas. The carriers' denial is not supported.
3. The fee guideline applicable to evaluation and management services including the office consultation in dispute is 28 Texas Administrative Code §134.203, Titled *Medical Fee Guideline for Professional Services*. In the absence of a contracted rate, the reimbursement for a professional service, including an evaluation and management service, is established under paragraph (c). 28 Texas Administrative Code §134.203 (c) states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. The term "Medicare payment policy" is defined for this rule by §134.203 (a)(5). The definition includes billing the correct codes as specified by Medicare.

   The Medicare billing policy applicable to the disputed service can be found at www.cms.gov in the CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 1875, Change Request (CR) 6740, dated December 14, 2009, effective January 1, 2010. CR#6740 states that the use of all consultation codes (ranges 99241-99245 and 99251-99255) was eliminated effective January 1, 2010. In lieu of consultation codes, participants were directed to use codes 99201-99205 that identify the complexity of the visit performed. The eliminated codes include 99244 which the requestor reported on its medical bills.

   The division concludes that the requestor failed to code the office consultation in dispute in accordance with the applicable Medicare policy in effect on the date the service in dispute was provided, thereby failing to meet the correct coding requirements of §133.20(c), and §134.203 (b)(1). For that reason, no reimbursement can be recommended.
4. CPT code 99358 is defined as "Prolonged evaluation and management service before and/or after direct patient care; first hour." The workers' compensation carrier denied payment because "185-The rendering provider is not eligible to perform the service billed". 22 Texas Administrative Code §75.17(c)(2)(A) states "Examination and Evaluation: (1) In the practice of Chiropractic, licensees of this board provide necessary examination and evaluation of services." The Division finds that 99358 is within the chiropractic scope of practice in Texas. The carriers' denial is not supported.
5. The prolonged service codes are meant to be reported in addition to Evaluation/Management codes when the length of time a physician spends with a claimant goes beyond what is typical for that service.

The Medicare billing policy applicable to the disputed service can be found at www.cms.gov in the CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 1490, Change Request (CR) 5972, dated April 11, 2008, effective July 1, 2008 which states "**30.6.15.2 - Prolonged Services Without *Direct* Face-to-Face *Patient Contact* Service (Codes 99358 - 99359)**

Contractors may not pay prolonged services codes 99358 and 99359, which do not require any direct patient *face-to-face* contact *(e.g., telephone calls)*. Payment for these services is included in the payment for direct face-to-face services that physicians bill. The physician cannot bill the patient for these services since they are Medicare covered services and payment is included in the payment for other billable services."

The requestor noted on the EMG/NCV SUPERBILL that code 99358 was for "Review of Medical Records." This service does not require any direct patient face-to-face contact with the claimant. Payment for this service is included in the payment for the face-to-face services that physicians bill.

Furthermore, the Medicare MLN Matters Number: MM5972, Related Change Request Number 5972 effective July 7, 2008 states "Documentation, however, is required to be in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services that you bill." A review of the medical records does not document the duration and content to support billing the prolonged service. As a result, payment cannot be recommended.

6. CPT code 99070 is defined as "Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)." The workers' compensation carrier denied payment because "185-The rendering provider is not eligible to perform the service billed" and VH04-Service does not fall within the scope of the providers practice".

   The Division finds that the suit referenced above did not address supplies; therefore, per 28 Texas Administrative Code §134.203(a)(6) supplies are within the scope of chiropractic practice; therefore, the respondent's denial based upon reason codes "185 and VH04" are not supported.

7. Per 28 Texas Administrative Code §134.203(a)(5), CPT code 99070 is subject to the reporting payment policies as set by CMS. CPT code 99070 is used to bill for supplies over and above those included in the office visit and/or service. A review of the records finds that the requestor did not list the supplies utilized to support billing of CPT code 99070. As a result, reimbursement is not recommended.

8. CPT code 99080 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form." The respondent denied reimbursement for this code based upon reason codes "185 and VH04."

   The Division finds that the suit referenced above did not address special reports; therefore, per 28 Texas Administrative Code §134.203(a)(6) special reports are within the scope of chiropractic practice; therefore, the respondent's denial based upon reason codes "185 and VH04" are not supported.

9. Per 28 Texas Administrative Code §134.203(a)(5), CPT code 99080 is subject to the reporting payment policies as set by CMS. CPT code 99080 is used to bill for special reports such as insurance forms that are not included in the office visit and/or service. The requestor noted on the EMG/NCV SUPERBILL that code 99080 was for a "Narrative Report." A review of the records finds that the requestor did not submit a copy of the narrative report to support billing of CPT code 99080. As a result, reimbursement is not recommended.

10. Disputed services 95900, 95903, and 95904 fall in the category of nerve conduction tests under applicable AMA current procedural terminology (CPT). These tests involve placing a stimulating electrode is directly over the nerve to be tested. These are surface tests that do not involve needles. According to the medical documentation found, these services were performed by Pedro J. Lozano D.C. (Doctor of Chiropractic). As stated in the Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Opinion dated April 5, 2012

    > In the second provision, paragraph(c)(3)(A), TBCE imposed certification and supervision requirements on any licenses who administered "electro-neuro diagnostic testing" that varied according to whether the testing was "surface (non-needle)" or involved the use of needles. The import or effect of paragraphs (c)(2)(D) and (c)(3)(A), as the parties agree, was that chiropractors with specified training and certification could utilize needle EMG in evaluating or examining patients. In their live petitions and summary-judgment motions, the Physician Parties challenged the validity of the two rule provisions **specifically addressing needle EMG** [emphasis added]- 75.17(c)(2)(D) and (c)(3)(A) – plus the general standard regarding use of needles-75.17(a)(3)."

    That is, surface tests were not in question during this suit. Pursuant to §75.17(c)(3)(A) effective December 24, 2009, *34 Texas Register 9208*, services 95900, 95903, and 95904 are within the scope of chiropractic practice because they are surface tests. Reimbursement is recommended for these services.

11. CPT code 95900 is defined as “Nerve conduction, amplitude and latency/velocity study, each nerve, motor, without F-wave study.”

    Per The National Correct Coding Initiative Policy Manual “The NCCI edit with column one CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column two CPT code 95900 (Motor nerve conduction studies without F-wave study, each nerve) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 95900 of this NCCI edit is appropriate only if the two procedures are performed on different nerves or at separate patient encounters.” The requestor utilized modifier 59 to indicate that CPT code 95900 was a separate procedure. A review of the submitted report, finds that the motor testing nerves without F-Wave studies was performed on the left and right radial nerves; therefore, reimbursement is recommended.

12. Because these studies, 95903, 95900 and 95904, are within the scope of chiropractic practice reimbursement is recommended in accordance with 28 Texas Administrative Code §134.203(c).

    Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
    (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

    (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.”

    To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

    The 2011 DWC conversion factor for this service is 54.54.

    The Medicare Conversion Factor is 33.9764

    Review of Box 32 on the CMS-1500 the services were rendered in zip code 77029, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Houston, Texas.

    Using the above formula, the Division finds the following:

Code	Calculation for Locality 0440218 Houston	Maximum Allowable
95903	(54.54/33.9764) x $69.69 for 4 Units	$447.47
95904	(54.54/33.9764) x $52.90 for 4 Units	$339.67
95900	54.54/33.9764) x $60.04 for 2 Units	$192.76
		$979.90

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the specified services. As a result, the amount ordered is $979.90.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $979.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		9/25/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.